IN THE COURT OF COMMON PLEAS OF ALLEGHENY COUNTY
FAMILY DIVISION

Phone: 412-350-5600

Member Name:_____
Docket Number:_____
PACSES Case Number:_____
Other State ID Number:_____

Please note: All correspondence must include the PACSES Case Number

PHYSICIAN VERIFICATION FORM

TO BE COMPLETED BY THE TREATING PHYSICIAN:

Physician's Name: _____
Physician's License Number: _____
Nature of patient's sickness or injury: _____
_____
_____
_____

(a) Date of first treatment: _____
(b) Date of most recent treatment: _____
(c) Frequency of treatments: _____
(d) Medication(s): _____

The patient has a medical condition that affects his or her ability to earn income from:
_____ through _____

If the patient is unable to work, when should the patient be able to return to work? Will there be limitations?
_____
_____

REMARKS:
_____
_____

Date:_____

Signed: _____
Signature of Treating Physician

I authorize my physician to release the the above information to the Allegheny County Domestic Relations Section

_____
Physician's Address

_____

_____ _____
Patient's Signature **Date**

_____
Physician's Phone Number